Ψ **Jason E. Mastor, M.D., P.A.** **Kristin C. Brown, PA-C, MMS**

Please read carefully and sign

PATIENT AUTHORIZATION RECORD

1. **CONSENT TO TREATMENT: I hereby authorize the physician in charge of my psychiatric care to oversee my treatment plan and monitor my psychiatric medications as required by my behavioral health needs as discussed by myself and my doctor.**
2. **AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION: I hereby authorize the physician to release information requested for continuation of treatment and claims purposes to my insurance carrier liable for their part of the charges incurred in the duration of my active coverage of my behavioral health benefits. Only information such as diagnostic and therapeutic information (including psychiatric, substance abuse or illness status such as HIV or etc.) shall be released according to guidelines of information needed and requested by said Insurance carrier to pay the claim or to authorize further treatment.**
3. **MEDICARE/MEDICAID/PATIENT CERTIFICATION/RELEASE INFORMATION &PAYMENT REQUEST: I certify that the information I give in application for payment XVII and /or XIX of the social security act is correct. I authorize any holder of behavioral health information regarding myself to release to the social security commission or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payments be made on my behalf. I assign the benefits payable for physician services to the physician furnishing these services or authorized said physician to submit a claim to Medicare or Medicaid for payment of these services. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLE AMOUNTS AND CO-INSURANCE AMOUNTS THAT ARE DUE PAYABLE BY ME ACCORDING TO MY BENEFIT PLAN.**
4. **ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize, request and direct any and all assigned Insurance companies to pay directly to the physician in the amount due according to my pending claim for behavioral healthcare. I agree, should the amount be insufficient to cover the entire expense, I will be responsible for the remaining payment according to the benefits coverage and/or treatment plan between myself and my listed physician. I am responsible for knowing my benefits coverage regarding in patient and out patient payable care. I agree to pay my portion of the in patient and out patient fees as directed upon final payment of my said Insurance carrier. *I understand that if I do not qualify for these benefits according to my specific Insurance plan, I will be held responsible for the full amount of the incurred charges.**
5. **GUARANTEE OF PAYMENT: for value received, the undersigned does agree to guarantee and promises to pay the physician all charges and expenses incurred, falling into patient responsibility, that is owed to said physician. If any action by Law or mediation is brought to enforce this agreement, the treating physician shall be entitled to reasonable attorney fees, court costs and reimbursement of any other costs regarding the collection process. I understand that all bills are payable and become due upon representation.**
6. **DENIAL OF PAYMENT AUTHORIZATION: the physicians office will make every effort to obtain payment, authorization /pre-certification for all managed care contractual agreements according to the said Insurance carrier for behavioral healthcare. However, if denial is received, the patient/guarantor of the contracted benefits will be responsible for all incurred charges and penalties based on the reason for denial due to non-coverage, deductible amounts, co-insurance amounts, exceeded visits limitations, failure of providing all Insurance coverage information correctly and any other reason that my insurance sees fit to deny due to coverage issues. I shall be responsible for all needed patient to Insurance negotiations regarding payment of treatment.**
7. **RELEASE OF RESPNOSIBILITY / LIABILTY FOR PERSONAL VALUABLES: I understand and agree that the said physician is NOT responsible for the loss or damage to any personal property/ belongings of the patient or his/her accompaniment to this office.**
8. **CONTINUATION OF CARE ASSISTANCE: I understand that, under the direct supervision of my treating physician, an Advanced Registered Nurse Practitioner, licensed therapist, social worker, case manager or office support staff may be utilized in my treatment. This will only occur with notice and based upon my specific treatment plan with myself and my physician. I reserve the right of refusal to this, however I understand it may compromise my treatment and can be considered as non-compliance of care. If needed, releases will be signed for my protection and filed with my records.**
9. **COMPLIANCE OF CARE GIVEN: I understand that I have given consent for said physician to treat my behavioral health needs and if I compromise that care in anyway it may be grounds for dismissal from this Psychiatric Practice. I understand that I have given this physician the right to handle my medicinal care regarding behavioral healthcare needs. If I take action against authorized care given, such as stop my medication, use street drugs or fail to inform the physician of all my behavioral or medical health problems. I am responsible for contacting my physician at once to inform them and seek immediate advisement.**

Patients Signature: _____Date: _____/_____/_____

Next of Kin/ Other Signature: _____Relationship: _____
Witness: _____